# TENNESSEE DEPARTMENT OF HEALTH

## OFFICE OF HEALTH STATISTICS

# Joint Annual Report Manual for Outpatient Diagnostic Center Facilities

## 2014

# JOINT ANNUAL REPORT MANUAL for Outpatient Diagnostic Center Facilities

# 2014

**STATE OF TENNESSEE**
Department of Health
Policy, Planning & Assessment
Office of Health Statistics
Tennessee Tower
2nd Floor
710 James Robertson Parkway
Nashville, TN 37243
615-741-1954

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***Before beginning your report go to the http://health.state.tn.us/statistics/jarodc.htm. website to first download your form and save it with your State ID Number, and Facility Name.***

***Example: 00000 John Doe Imaging ODC***



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# SECTION I

## Introduction

STATE OF TENNESSEE
**DEPARTMENT OF HEALTH**
DIVISION OF POLICY, PLANNING, & ASSESSMENT
2nd FLOOR, ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PKWY
NASHVILLE, TENNESSEE 37243

January 15, 2015

**LETTER OF INFORMATION**

To: Administrators of all licensed Outpatient Diagnostic Centers

We are pleased to provide your facility with an Excel program for entering data into the Joint Annual Report (JAR). Per Tennessee Code Annotated 1200-8-35-11, "The Joint Annual Report of Outpatient Diagnostic Centers shall be filed with the Department of Health."

**The JAR form in Excel format, a manual for completing this form, and a "Tips to Avoid Common Errors" sheet can be found at http://health.state.tn.us/statistics/jarodc.htm. It is recommended that you read and print these documents before completing your report. The "Tips to Avoid Common Errors" document is also located as a tab on the excel file for your reference.**

Please note that all facilities are requested to report for the period January 1, 2014 through December 31, 2014. All information submitted should be complete and accurate so that the compiled data will be useful for the legislature, the public, and this department for statistical analyses and health planning processes. The reports are due back to our office by **March 3, 2015**. Any facility that fails to report its data may be issued deficiencies.

Once the Excel file is complete, facilities should check the **Error** tab and resolve any problems before submitting.

***The Excel file must be saved and renamed with the facility's State ID and Name. Files submitted incorrectly will be returned for correction.**

Renaming example: 00000_ABC Center

If you have any questions concerning the report or have difficulties accessing the website, please contact Cheryl Hines at (615) 532-7888 or by email Cheryl.Hines@tn.gov.

Thank you for the work you do in providing this required data and for all you do for the health and well-being of Tennesseans. We truly appreciate your cooperation.

Sincerely,

Lori B. Ferranti, PhD, MSN, MBA, Assistant Commissioner,
Division of Policy, Planning and Assessment

# Introduction to Joint Annual Reporting

The Health Statistics Facilities unit collects data from a variety of licensed health facilities through annual reports known as Joint Annual Reports (JARs). Data collected include facility locations, services provided, patient origin by county, and financial indicators.

# SECTION II

## Rules and Regulations for Reporting

# General Reporting Requirements

**Per T. C. A. 1200-8-35-11 The Joint Annual Report of Outpatient Diagnostic Centers shall be filed with the department. The forms are furnished online to each Outpatient Diagnostic Center by the department each year and the forms must be completed and returned to the department as required.**

All facilities are requested to report for the calendar year beginning January 1st through December 31st. Information should be complete and accurate as possible so that the compiled data will be useful for the legislature, the public and the department's statistical analyses and health planning process.

**Forty-five days after the facility gets the form from the department it needs to be completed. Any facility that fails to report its data could be issued deficiencies.**

Data Editing and Quality Control

The department will review data submitted. Incomplete reports or inaccuracies will be queried. The facility will be asked to investigate these errors and to supply correct information **within 15 working days** of the date that the error is reported to the facility.

# Data System Summary

**Data Set Name:** Outpatient Patient Diagnosis **(**ODC)
**Location/Owner of Data Set:** Tennessee Department of Health, Office of Health Statistics
**Contact Person:** **Cheryl Hines** (615) 532-7888 Email Address: Cheryl.Hines@tn.gov
**Purpose for Which Data Collected:** This system collects and compiles data that will be useful for the legislature, the public and the department's statistical analyses and health planning process.
**Process for Accessing Data:** Requests for data are handled by Statistical Services. Contact Statistical Services at (615) 741-4939 or HealthStatistics.Health@tn.gov.
**Description:**
**Method of Data Collection:** JAR for ODC forms
**Percent Return:** 95% - 99%
**Frequency of Updating:** Annually
**Years of Data:** One
**Types of Data Output Available:** Excel format files
**Cost for Data Output:** No
**Standard Reports Generated:** ODC Joint Annual Reports

# Timing and Frequency of Data Submission

All data submitted must be approved by the Department of Health. The Department of Health must receive all required data from the facility 45 days following the close of the calendar year.

| Date Sent to Facility | Date Due to TDOH | Reporting Period |
|---|---|---|
| January 15th, 2015 | March 15th , 2015 | January 1st through December 31st, 2014 |

**Data reported to the Department of Health should be <u>e-mailed</u> to:**

**Facilities**
**Office of Health Statistics**
**Andrew Johnson Tower**
**2nd Floor**
**710 James Robertson Boulevard**
**Nashville, Tennessee 37243**

**<u>JARODC.Health@tn.gov</u>**

# ODC JAR Contacts

Technical questions regarding the Tennessee Outpatient Diagnostic Center Joint Annual Reports should be directed to:

**Cheryl Hines***
**Facilities Unit**
**Office of Health Statistics**
**(615) 532-7888**
**Cheryl.Hines@ tn.gov**

**All other JAR inquiries should be referred to:**
**Trent Sansing**
**Facilities Unit**
**Office of Health Statistics**
**(615) 253-4702**
**Email to trent.sansing@tn.gov**

# SECTION III

## Schedules

| Schedule A – Identification | Facility | Required Fields - Yes |
|---|---|---|

*The State Identification number for all ODC facilities is found on the "State ID" sheet of the computer form. This information is protected and cannot be accessed. If the facility had a name change that is not reflected on this data base, please contact Facilities, TN Department of Health.* ***See page 11 for all contact information.***

**Facility** – **State ID**
The **State ID** is accessed from the "drop" box on the computer form. Once the State ID is selected, *the Street Address, City, State, County, and Zip Code* fields will automatically populate the form. This ID will automatically populate Schedule A through Administration Declaration. **DO NOT KEY in this field.** Select the **State ID** from the "drop" box for this field.

**Facility – Did the facility's name change during the reporting period?**
This is a Required Field and must be answered with "Yes" or "No".
**DO NOT KEY in this field.** Make the selection from the "drop" box for this field.

If **"Yes"**, key in the facility's Prior Name.

If **"No"**, leave blank.

**Facility – Telephone**
This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. **DO NOT** use brackets or dashes. This field will automatically place the number in the telephone format (123) 456-7890.

**Facility – Mailing Address same as Street Address?**
This is a Required Field and must be answered with "Yes" or "No". **DO NOT KEY in this field.** Make the selection from the "drop" box for this field.

If "**Yes**", the Mailing Address, City, State and Zip Code will be automatically populated.

If "**No**", manually key in the following information
Mailing Address – Put in the Mailing Address for the facility (P. O. Box, Street, etc.)
Mailing City – Put in the City for the facility
Mailing State – **DO NOT KEY in this field**. Make the selection from the "drop" box.
Mailing Zip Code – Put in the facility's zip code. The 4 digit extension may also be added if available.

| Schedule A – Identification **(cont.)** | Preparer | Required Fields - Yes |
|---|---|---|

*The person that prepared this form information should go here.*

**Preparer – Name**
Enter in the name of the person who prepared the form.

**Preparer – Title**
Enter in the work title of the person who prepared the form i.e. Supervisor, etc.

**Preparer – Phone**
This is a 10 digit field. Enter the telephone number starting with the area code, i.e. 1234567890. **DO NOT** use brackets or dashes. This field will automatically place the number in the telephone format (123)456-7890.

**Preparer – E-Mail Address**
Enter in a valid work e-mail address of the person who prepared the "JAR" form.

| Schedule A – Identification **(cont.)** | Reporting Period | Required Fields - Yes |
|---|---|---|

*In the event your organizations' reporting period is different from that of our January 1st through December 31st, 2014 requested reporting period, due to your facility having newly opened or your facility having closed prior to December 31st; please provide the data including the actual beginning and ending dates for the period of time you are reporting for your facility.*

**Reporting Period – <u>Is the Reporting Period from January 1st through December 31st of the year specified above?</u>**
This is a Required Field and must be answered with "Yes" or "No". **<u>DO NOT KEY in this field.</u>** Make the selection from the **"drop"** box for this field.

If **"Yes",** the Beginning and Ending date fields will be automatically populated.

If **"No"**, then key in the dates. The format for the Beginning and Ending date is MMDDYYYY.

*If the reporting year is contained within a Leap Year, please use 366 reporting days. Example the year 2012 was a Leap Year.

| Schedule A – Identification **(cont.)** | Administration | Required Fields - Yes |
|---|---|---|

**Administration – Administrator's Name**
Put in Administrator's Name of facility along with any title if present or applicable, i.e. RN, Dr., etc.

**Administration – Medical Director's Name**
Enter in the Medical Director's Name of facility along with any title if present or applicable, i.e. RN, Dr., etc.

| Schedule B – Organization Structure | Owner | Required Fields – Yes |
|---|---|---|

**Owner – Name**
Put in the owners' complete Name (along with suffix if applicable).

**Owner – Street**
Put in the owner's Street address. This may also include Apt. No., P. O. Box, etc.

**Owner – City**
Put in the owner's City.

**Owner –State**
**DO NOT KEY in this field.** Make the selection from the **"drop"** box for this field.

**Owner – Zip Code**
Put in the owner's zip code. The 4 digit extension may be added if available.

**Owner – Telephone**
This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. Do not use brackets or dashes. This field will automatically place the number in the telephone format (123)456-7890.

| Schedule B – Organization Structure **(cont.)** | Owner Type | Required Fields – Yes |
|---|---|---|

*The type of legal entity, except proprietorship, general partnerships and government entities, can be confirmed by entering the legal entity's name into a search at the Secretary of State web site: http://www.tennesseeanytime.org/soscorp/.*

**Owner Type – <u>For Profit</u>**
Select only one from this group. A "drop box" is provided to place an **"X**" beside the selection. If you choose one from this group DO NOT choose another from another group.

**Owner Type – <u>Not For Profit</u>**
Select only one from this group. A "drop box" is provided to place an **"X"** beside the selection. If you choose one from this group DO NOT choose another from another group.

**Owner Type – <u>Government</u>***
Select only one from this group. A "drop box" is provided to place an **"X"** beside the selection. If you choose one from this group DO NOT choose another from another group.

**Other Government, Specify:* Information must be provided for this field if selected.

| Schedule B – Organization Structure **(cont.)** | Managed By | Required Fields – Yes |
|---|---|---|

***Select only one from this group.*** *A "drop box" is provided to place an* ***"X"*** *beside the selection. If you choose one from this group DO NOT choose one from another group.*

**Management Provided By – Owner**
Please give Management Name. No other information is required.

**Management Provided By – Contract with Firm**

**Name** – Put in Firm Name

**Street** – Put in Firm Street

**City** -–– Put in Firm City

**State** – **DO NOT KEY in this field.** Make the selection from the **"drop"** box for this field.

**Zip Code** – Put in Firm 5 digit Zip Code. The 4 digit extension may also be given if available

**Phone Number** – This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. This field will automatically place the number in the telephone format (123)456-7890.

**Management Provided By – Other (Specify)**

**Name** – Put in Other Name

**Street** – Put in Other Street

**City** -–– Put in Other City

**State** – **DO NOT KEY in this field.** Make the selection from the **"drop"** box for this field.

**Zip Code** – Put in Other 5 digit Zip Code. The 4 digit extension may also be given if available

**Phone Number** – This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. This field will automatically place the number in the telephone format (123)456-7890.

| Schedule B – Organization Structure **(cont.)** | Building Owner | Required Fields – Yes |
|---|---|---|

**Building Owner – <u>Name</u>**
Put in the building owners' Name.

**Building Owner – <u>Street</u>**
Put in the building owner's Street.

**Building Owner – <u>City</u>**
Put in the building owner's City.

**Building Owner – <u>State</u>**
**<u>DO NOT KEY in this field.</u>** Make the selection from the **"drop"** box for this field.

**Building Owner – <u>Zip Code</u>**
Put in the owner's zip code. The 4 digit extension may also be added if available.

**Building Owner – <u>Telephone</u>**
This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. Do not use brackets or dashes. This field will automatically place the number in the telephone format (123)456-7890.

| Schedule B – Organization Structure **(cont.)** | Building | Required Fields – Yes |
|---|---|---|

**Building – <u>Do you know the year of the original Construction Date?</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box.

If **"Yes"**, the **Year** must be keyed in. The format for Year is **"YYYY".**

If **"No"**, leave blank.

**Building – <u>Has the building had a major renovation?</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box.

If **"Yes"**, the **Year** must be keyed in. The format for Year is **"YYYY".**

If **"No"**, leave blank.

| Schedule B – Organization Structure **(cont.)** | Type of Facility | Required Fields – Yes |
|---|---|---|

*Please check Yes or No in **each** of the four types to describe your facility and include the information requested for that type.*

**Type of Facility – <u>Free-Standing</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. No other information is required.

**Type of Facility – <u>Hospital Based</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If ***"Yes",*** provide the Name, Street, City, State and Zip Code**.**
***State:*** **<u>DO NOT KEY in this field.</u>** Make the selection from the **"drop"** box for this field.

If "**No"**, leave blank.

**Type of Facility – <u>Doctor's Office</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If ***"Yes",*** provide the Name, Street, City, State and Zip Code**.**
***State:*** **<u>DO NOT KEY in this field.</u>** Make the selection from the **"drop"** box for this field.

If "**No"**, leave blank.

**Type of Facility – <u>Other</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If ***"Yes",*** provide the Name, Street, City, State and Zip Code**.**
***State:*** **<u>DO NOT KEY in this field.</u>** Make the selection from the **"drop"** box for this field.

If "**No"**, leave blank.

| Schedule B – Organization Structure **(cont.)** | Type of Service | Required Fields – Yes |
|---|---|---|

**Type of Service – <u>Multi-Specialty</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. . No other information is required.

**Type of Service – <u>Limited-Purpose</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. No other information is required.

**Type of Service – <u>Cancer Treatment and Radiation Clinic</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. No other information is required.

**Type of Service – <u>Other, Specify</u>***
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

*If **"Yes",** please provide description of Type of Service.

*If **"No"**, leave blank.

**Certifications – <u>Participation in TennCare</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, enter the Provider Number.
If **"No"**, leave blank.

**Certifications – <u>Participation in Medicare</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, enter the Provider Number.
If **"No"**, leave blank.

| | | |
|---|---|---|
| | Audits | |

**Accreditation and Audits – <u>Joint Commission on Accreditation of Healthcare Organizations (JCAHO)</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

**Accreditation and Audits – <u>Clinical Laboratory Improvement Amendments (CLIA)</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

**Accreditation and Audits – <u>Laboratory Proficiency Testing</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

**Accreditation and Audits – <u>American Association of Blood Banks (AABB)</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

**Accreditation and Audits – <u>American Osteopathic Association (AOA)</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

| | | |
|---|---|---|
| | Audits | |

**Accreditation and Audits – <u>College of American Pathologist (CAP)</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

**Accreditation and Audits – <u>American College of Radiology (ACR)</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

**Accreditation and Audits – <u>Other, Specify 1, 2, and 3.</u>***
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

*If **"Yes"**, must specify other services in corresponding cell. Provide the Approval Year and Expiration Year. The format for Year is "YYYY".
*If **"No"**, leave blank.

| | | |
|---|---|---|
| Schedule D – Availability and Utilization of | Cardiopulmonary | Required Fields – Yes |

| | | |
|---|---|---|
| Svcs/Equip | | |

*Please provide information requested and indicate the number of patients and diagnostic procedures for those services during the reporting period. Number of patients may include duplicates because the same patient may receive several of the services listed. Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.*

**Cardiopulmonary Type of Service – Electroencephalogram (EEG)**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Cardiopulmonary Type of Service – Electrocardiogram (EKG)**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Cardiopulmonary Type of Service – Holter Monitoring**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Cardiopulmonary Type of Service – Exercise Tolerance Testing**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Cardiopulmonary Type of Service – Cardiac Catheterization**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

| | | |
|---|---|---|
| Svcs/Equip (cont.) | | |

**Cardiopulmonary Type of Service – <u>Percutaneous Transiuminal Coronary Angioplasty</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

| Schedule D – Availability and Utilization of Svcs/Equip (cont.) | Radiology<br>*Type of Service* | Required Fields – Yes |
|---|---|---|

**Radiology Type of Service – <u>Radiography (Diagnostic and Special Procedures-e.g. Angiography)</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Service <u>– Ultrasound (General/Vascular/Cardiac)</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Service – <u>Nuclear Medicine</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

| Schedule D – Availability and Utilization of Svcs/Equip (cont.) | *Type Equipment* | Required Fields – Yes |
|---|---|---|

*Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.*

**Radiology Type of Equipment on Site –Position Emission Tomography (PET scan)**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site – Computed Tomography (CT Scan)**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site – Ultrafast CT**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site – Magnetic Resonance Imaging (MRI)**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site – Hi Field MRI and Open MRI**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

| | | |
|---|---|---|
| Schedule D – Availability and Utilization of Svcs/Equip (cont.) | Radiology<br>*Type Equipment* | Required Fields – Yes |

*Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.* **

**Radiology Type of Equipment on Site –Megavoltage Radiation Therapy**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site –Stereotactic Procedure (including Breast Biopsy)****
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter number of Fixed plus Mobile Patients and/or Procedures.*

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site – Mammography****
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter number of Fixed plus Mobile Patients and/or Procedures.*

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

| Schedule D – Availability and Utilization of Svcs/Equip (cont.) | Other<br>*Type of Service* | Required Fields – Yes |
|---|---|---|

**Other Type of Service – <u>Vascular Embolization</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Other Type of Service – <u>Anesthesia</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Other Type of Service – <u>Ultrasound (ACR Accredited Breast/Pelvic/OB)</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.
Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Other Type of Service – <u>Chemotherapy</u>**
**<u>DO NOT KEY in this field.</u>** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

| Schedule D – Availability and Utilization of Svcs/Equip (cont.) | Other *Type Equipment* | Required Fields – Yes |
|---|---|---|

*Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.*

**Other Type of Equipment on Site – Lithotripsy**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and /or Procedures.*

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Other Type of Equipment on Site – Bone, Densitometry**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If "**Yes"**, enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and /or Procedures.*

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Other Type of Equipment on Site – Other, Specify**
**DO NOT KEY in this field.** This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If "**Yes**", provide Other description for Type of Service. Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and /or Procedures. ***Procedures must equal or exceed number of Patients*.***

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

| Schedule D – Availability and Utilization of Svcs/Equip | Total and Rooms | Required Fields – Yes |
|---|---|---|

| | | |
|---|---|---|
| (cont.) | | |

**Total – Number of patients and diagnostic procedures during this reporting period.**
**DO NOT KEY in this field.** This field is cumulative of the Cardiopulmonary, Radiology, and Other field of patients and diagnostic procedures.

**Total – <u>Unduplicated patients</u>*****
This is a Required Field. The number of actual individuals served during the reporting period. This may be less than the number of patients and diagnostic procedures reported. **DO NOT ENTER ZERO** in this field. Blank fields represent zero patients and/or procedures.

**Rooms – <u>Number of Diagnostic Procedure rooms</u>**
This is a Required Field and must be answered.

***This count must MATCH Total Patients Served. See page 34.**

**Number of Patients Served By Age – <u>Gender</u>**
**DO NOT ENTER ZERO** in these fields. Provide Age by Gender information. Blank fields represent zero patients.

**Number of Patients Served By Age – <u>Race</u>**
**DO NOT ENTER ZERO** in these fields. Provide Age by Race information. Blank fields represent zero patients.

**Number of Patients Served - <u>Total Patients Served</u>*****
This is a calculated field of Patient Age by Gender and Race. Patients by Gender must equal to Patients by Race for each Age group represented.

| | | |
|---|---|---|
| Schedule E –Patient Characteristics | | |

| | | |
|---|---|---|
| (cont.) | Number of Patients TN Origin | Required Fields – Yes |

**Number of Patients Served – <u>Tennessee Patients</u>**
**DO NOT ENTER ZERO** in these fields. Please record the number of Tennessee patients who received services during the reporting period in the corresponding county cells. Blank fields represent zero patients.

**Number of Patients Served – <u>Total Tennessee Patients</u>**
This is a calculated field. The number "0" will automatically appear in the corresponding cell until data is placed in the patient county cells.

| | | |
|---|---|---|
| Schedule E –Patient Characteristics | | |

| | | |
|---|---|---|
| (cont.) | Number of Patients Out of State Origin | Required Fields – Yes |

**Number of Patients Served – <u>Out-of-state & Other State or Country Patients</u>**
**DO NOT ENTER ZERO** in these fields. Please record the number of Out-of-state and or Other State/Country patients who received services during the reporting period in the corresponding cells. Blank fields will represent zero patients.

**Number of Patients Served – <u>Total Non-Tennessee Patients</u>**
This is a calculated field. The number "0" will automatically appear in the corresponding cell until data is placed in the Out-of-state and or Other State/Country fields.

**Number of Patients Served – <u>Total Tennessee and Non-Tennessee Patients</u>******
This is a cumulative calculated field. The number "0" will automatically appear in the corresponding cell until data is placed in the County, Out-of-state, and Other State or Country fields.

*******This total must equal the <u>Total Patient Served field</u> in Schedule E***

| | | |
|---|---|---|
| Schedule F –Financial Data | Expenses | Required Fields – Yes |

**Expenses – Payroll**
Include salaries for all full-time and part-time personnel who are included in Schedule G.
This is a required field. Data must be placed in this field. This field will accept zero (0).

**Expenses – Fringe Benefits**
Social Security, group insurance, retirement benefits, etc.
This is a required field. Data must be placed in this field. This field will accept zero (0).

**Expenses – Other Operating Expenses**
These are expenses for all contract staff, professional fees, energy expense (oil, natural gas, electricity, etc.) and all other operating expenses.
This is a required field. Data must be placed in this field. This field will accept zero (0).

**Expenses – Depreciation Expense**
This is a required field. Data must be placed in this field. This field will accept zero (0).

**Expenses – Non-Operating Expenses**
Include all other expenses for interest, taxes, real estate ease expenses, and other non-operating expenses.
This is a required field. Data must be placed in this field. This field will accept zero (0).

| Schedule F –Financial Data | Patient Revenue | Required Fields – Yes |
|---|---|---|

**Government – Gross Patient Charges**
This is the sum of the facility's established rate for all services rendered to patients during the reporting year. *Show the revenue source from Medicare, TennCare, and Other Government.*
This is a required field. If there are no transactions enter zero (0).

**Government – Adjustment to Charges**
The difference between the gross patient charges and the actual amount of payment received by the facility during the reporting period should be reported here. Adjustments to previous year's revenue (Medicare or TennCare) should be reported as non-operating revenue, **not as current year adjustments**.
*Show the revenue source from Medicare, TennCare, and Other Government.*
This is a required field. If there are no transactions enter zero (0).

**Government – Total Government Gross Patient Charges and Adjustment to Charges**
This is a cumulative calculated field of Gross Patient Charges and Adjustment to Charges field. The number "0" will automatically appear in this cell until an amount is placed in these fields.

**Non-Government – Gross Patient Charges**
This is the sum of the facility's established rate for all services rendered to patients during the reporting year. *Show the charges are from "Self-Pay", Insurance, Other Non-Government.*
This is a required field. If there are no transactions enter zero (0).

**Non-Government Revenue Source – Adjustment to Charges**
The difference between the gross patient charges and the actual amount of payment received by the facility during the reporting period should be reported here. Adjustments to previous year's revenue (Medicare or TennCare) should be reported as non-operating revenue, not as current year adjustments.
*Show the charges are from "Self-Pay", Insurance, Other Non-Government.*
This is a required field. If there are no transactions enter zero (0).

**Non-Government Revenue Source – Total Non-Government**
This is a cumulative calculated field of the Non-Government Gross Patient Charges and Non-Government Adjustment to Charges fields. The number "0" will automatically appear in this cell until an amount is placed in these fields.

**Patient Revenue – Total Patient Revenue**
This is a cumulative calculated field. The number "0" will automatically appear in this cell and sums the amounts in the *Total Government plus Total Non-Government* cells.

| Schedule F –Financial Data (cont.) | Patient Revenue | Required Fields – Yes |
|---|---|---|

**Patient Revenue – <u>All Non-Patient Revenue</u>**
This is a required field. Data must be placed in this field. If there are no transactions enter zero (0).

**Patient Revenue – <u>Net Patient Revenue</u>**
This is a calculated field. The difference obtained by subtracting Adjustments to Charges from Gross Patient Charges. This difference represents the actual amount of revenue that the facility received.

**Patient Revenue – Total Net Revenue: <u>Net Total Patient Revenue plus All Non-Patient Revenue</u>**
This is a calculated field. This is the sum of the Total patient Revenue plus All Non-Patient Revenue.

| Schedule F –Financial Data (cont.) | Non-Government Adjustment | Required Fields – Yes |
|---|---|---|

**Non-Government Adjustment – <u>Bad Debt</u>**
Uncompensated care for which the facility directly billed the patient and for which the patient should reasonably be expected to pay.
This is a required field. If there are no transactions enter zero (0).

**Non-Government Adjustment – <u>Charity Care</u>**
Services provided to medically needy persons for which the facility does not expect payment.
This is a required field. If there are no transactions enter zero (0).

**Non-Government Adjustment – <u>Other</u>**
Any other adjustments that are not appropriately reported in either Bad Debt or Charity
This is a required field. If there are no transactions enter zero (0).

**Non-Government Adjustment –<u>Total Non-Government Adjustment to Charges Subcategories</u>**
This is a cumulative calculated field. The number "0" will automatically appear in this cell and sums the amounts in the Bad Debt, Charity Care, and Other cells.

| Schedule G – Personnel | Type of Personnel by Service | Required Fields – Yes |
|---|---|---|

*Please indicate the number of paid personnel as of the last day of reporting period. Do not include a type of personnel for which you do not provide that type of service. For example, do not include Physical Therapist unless you provide Physical Therapy Services.*

**Full Time Equivalent (FTE)**
Part-time is the Number of hours worked by part-time employees per week/40.

Example: Three Registered Nurses, each working 20 hours a week, the FTE would be (3X20)/40=1.5.

**Additional Example of FTE**

40 Hours = 1.00
30 Hours = .75
20 Hours = .50
10 Hours = .25

For the purpose of this calculation if your agency reimburses employees per visit rather than per hour worked, one visit equals one hour in FTE.

*The sum of full-time personnel plus part time personnel (in full-time equivalents) added together equals the total number of full-time equivalents.*

**Type Administrators – Employee and Contract – Full-Time / Part-Time**
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Medical Director – Employee and Contract – Full-Time / Part-Time**
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Physicians (M.D. and D. O.) – Employee and Contract – Full-Time / Part-Time**
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Dentist – Employee and Contract – Full-Time / Part-Time**
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Financial/Billing Personnel – Employee and Contract – Full-Time / Part-Time**
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Nursing (R.N., L.P.N., and Ancillary) – Employee and Contract – Full-Time / Part-Time**
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Medical Records – Employee and Contract – Full-Time / Part-Time**
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Registered Technologist – Employee and Contract – Full-Time / Part-Time**
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Technical – Employee and Contract – Full-Time / Part-Time**
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Maintenance/Services – Employee and Contract – Full-Time / Part-Time**
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Other 1, 2, and 3 Specify – Employee and Contract – Full-Time / Part-Time**
*Supply name of other service if indicated.* Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type – <u>Total Number of Personnel by Type</u>**
This is a cumulative calculated field. The number "0" will automatically appear in this cell and sums the amounts in the *Employee Full-Time, Employee Part-Time, Contract Full-Time, and Contract Part-Time cells separately*.

| Schedule G – Personnel (cont.) | Nursing Personnel – RN | Required Fields – Yes |
|---|---|---|

*Please indicate the number of personnel as of the last day of the reporting period.*

**Registered Nurses – <u>Highest Education Level – Number Currently Employed</u>**
Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Registered Nurses – <u>Highest Education Level – Number of Budgeted Vacancies</u>**
Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Registered Nurses – <u>Highest Education Level – Average Number of Weeks Required to Recruit Staff</u>**
Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Registered Nurses – <u>Highest Education Level – Number Added in Past 12 Months</u>**
Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Registered Nurses – <u>Highest Education Level – Number Eliminated in Past 12 Months</u>**
Associate, Diploma, Bachelors, Masters, and Doctorate employed in Clinical and Administration: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Registered Nurses – <u>Highest Education Level – Total</u>**
This is a cumulative calculated field. The number "0" will automatically appear in this cell and sums the amounts in the *Number Currently Employed, Number Budgeted Vacancies, Number Added in Past 12 Months, and Number Eliminated in Past 12 Months (Clinical and Administrative) cells separately.*

| Schedule G – Personnel (cont.) | Nursing Personnel – Advanced | Required Fields – Yes |
|---|---|---|

*Please indicate the number of personnel as of the last day of the reporting period.*

**Advanced Practical Nurses – Category – Number Currently Employed**
*Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Advanced Practical Nurses – Category – Number of Budgeted Vacancies**
*Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Advanced Practical Nurses – Category – Average Number of Weeks Required to Recruit Staff**
*Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Advanced Practical Nurses – Category – Number Added in Past 12 Months**
*Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Advanced Practical Nurses – Category – Number Eliminated in Past 12 Months**
*Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist employed in Clinical and Administration*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Advanced Practical Nurses – Category – Total**
This is a cumulative calculated field. The number "0" will automatically appear in this cell and sums the amounts in the *Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist employed in Number Added in Past 12 Months and Number Eliminated in Past 12 Months (Clinical and Administrative) cells separately.*

| Schedule G – Personnel (cont.) | Nursing Personnel – Other | Required Fields – Yes |
|---|---|---|

*Please indicate the number of personnel as of the last day of the reporting period.*

**Other Nurses – Other Nursing Staff – Number Currently Employed**
*Licensed Practical Nurses, Certified Nurses' Aides, Other 1, Specify, Other 2, Specify*: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Other Nurses – Other Nursing Staff – Number of Budgeted Vacancies**
*Licensed Practical Nurses, Certified Nurses' Aides, Other 1, Specify, Other 2, Specify*: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Other Nurses – Other Nursing Staff – Average Number of Weeks Required to Recruit Staff**
*Licensed Practical Nurses, Certified Nurses' Aides, Other 1, Specify, Other 2,Specify*: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Other Nurses – Other Nursing Staff – Number Added in Past 12 Months**
*Licensed Practical Nurses, Certified Nurses' Aides, Other 1, Specify, Other 2, Specify*: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Other Nurses – Other Nursing Staff – Number Eliminated in Past 12 Months**
*Licensed Practical Nurses, Certified Nurses' Aides, Other 1, Specify, Other 2, Specify*: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

| Schedule G – Personnel (cont.) | Nursing Personnel – Contract | Required Fields – Yes |
|---|---|---|

*Please indicate the number of personnel as of the last day of the reporting period.*

**Contract Nursing – Does your organization use contract nursing personnel?**
This is a Required Field and must be answered with "Yes" or "No". **DO NOT KEY in this field.** Make the selection from the "drop" box for this field.

If **"Yes"**, indicate the number of contract personnel in the categories below.
If **"No"**, continue to the next schedule. Leave fields blank.

**Contract Nursing – Number Currently Employed**
*Registered Nurses, Licensed Practical Nurses, and Certified Nurses' Aides*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Contract Nursing – Number of Budgeted Vacancies**
*Registered Nurses, Licensed Practical Nurses, and Certified Nurses' Aides*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Contract Nursing – Average Number of Weeks Required to Recruit Staff**
*Registered Nurses, Licensed Practical Nurses, and Certified Nurses' Aides*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Contract Nursing – Number Added in Past 12 Months**
*Registered Nurses, Licensed Practical Nurses, and Certified Nurses' Aides*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Contract Nursing – Number Eliminated in Past 12 Months**
*Registered Nurses, Licensed Practical Nurses, and Certified Nurses' Aides*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

| Schedule H – Personnel | Medical Staff | Required Fields – Yes |
|---|---|---|

*Please include all physicians, whether considered active or associate.*
*Active: Employed and practicing at the facility.*
*Associate: Has privileges to practice at the facility but is not employed at the facility.*

**Medical Staff – Specialty – Total number of Medical Staff**
*Cardiologist, Neurologist, Pathologist, Radiologist, Technician, Other 1 (specify), Other 2 (specify)*: Indicate number of medical staff as of the last day of reporting. If data is given for ***Other 1 or 2***, please describe the Other Medical Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Medical Staff – Specialty – Number of Medical Staff who are Board Certified**
*Cardiologist, Neurologist, Pathologist, Radiologist, Technician, Other 1 (specify), Other 2 (specify)*: Indicate number of medical staff as of the last day of reporting. If data is given for ***Other 1 or 2***, please describe the Other Medical Staff for that field. Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

| Schedule Adm. Dec. – Administrator's Declaration | Administrator's Declaration | Required Fields – Yes |
|---|---|---|

**Administrator Declaration – "I, the administrator, declare that I have examined this report and to the best of my knowledge and belief, it is true, correct, and complete."**
This is a Required Field and must be answered with "Yes" or "No". **DO NOT KEY in this field.** Make the selection from the "drop" box for this field.
**If the answer is "Yes", then key the date acknowledged. The format is MM/DD/YYYY.**

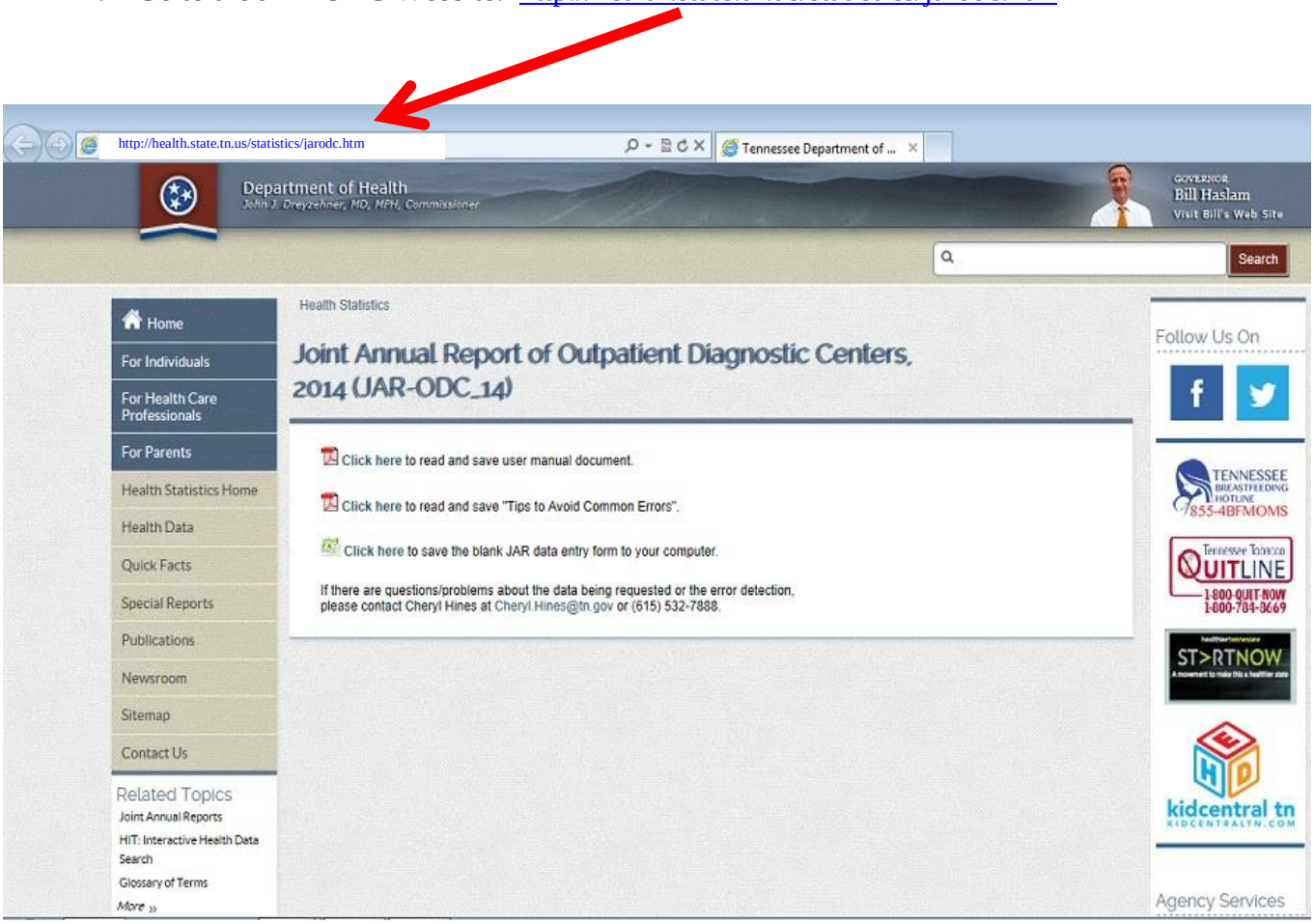
# Appendix

*The mission of the Department of Health is to protect, promote and improve the health and prosperity of people in Tennessee.*

# 2014 Joint Annual Report – ODC Manual

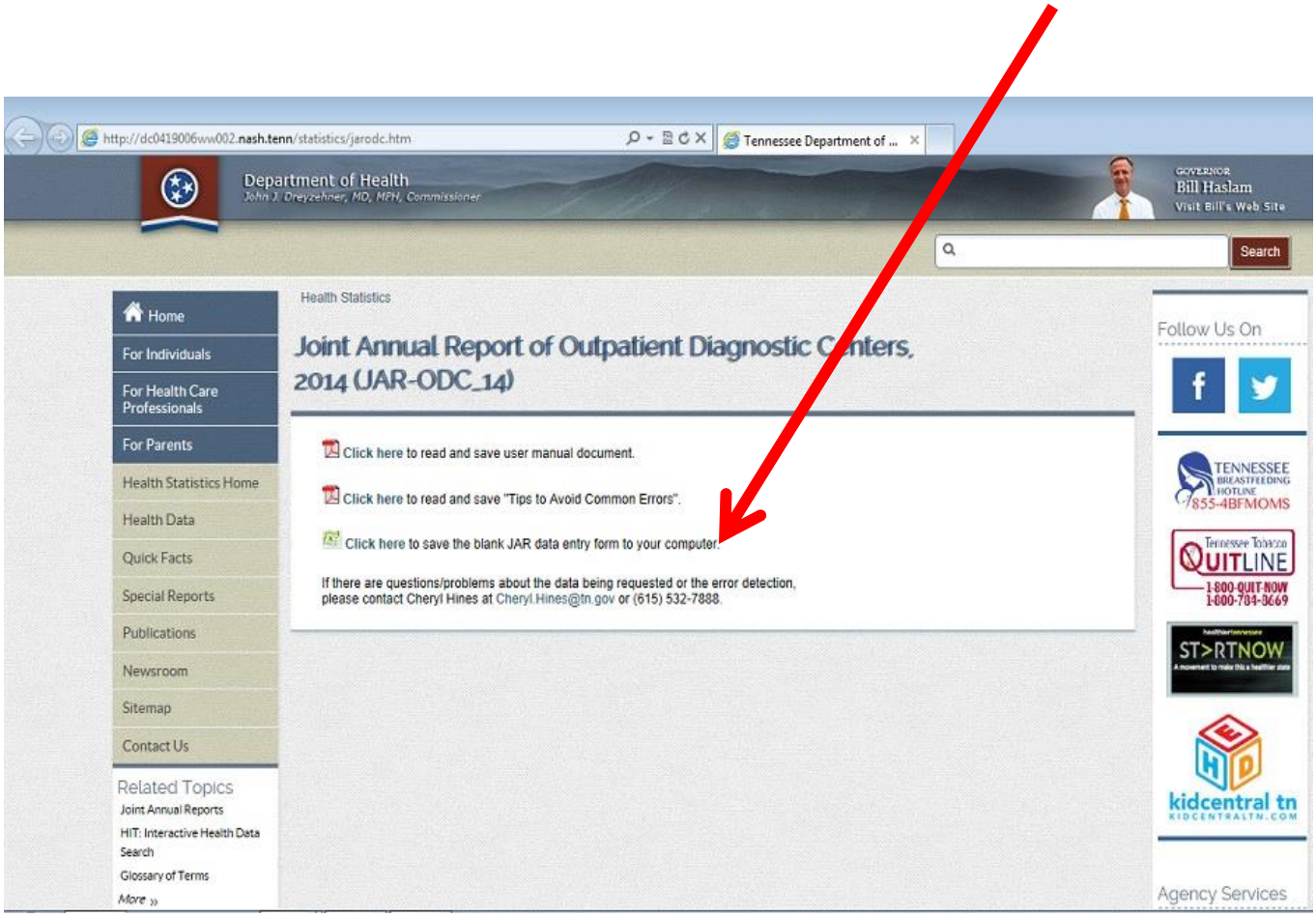
## "Saving your Joint Annual Report Form"

1. Go to the JAR ODC Website: http://health.state.tn.us/statistics/jarodc.htm



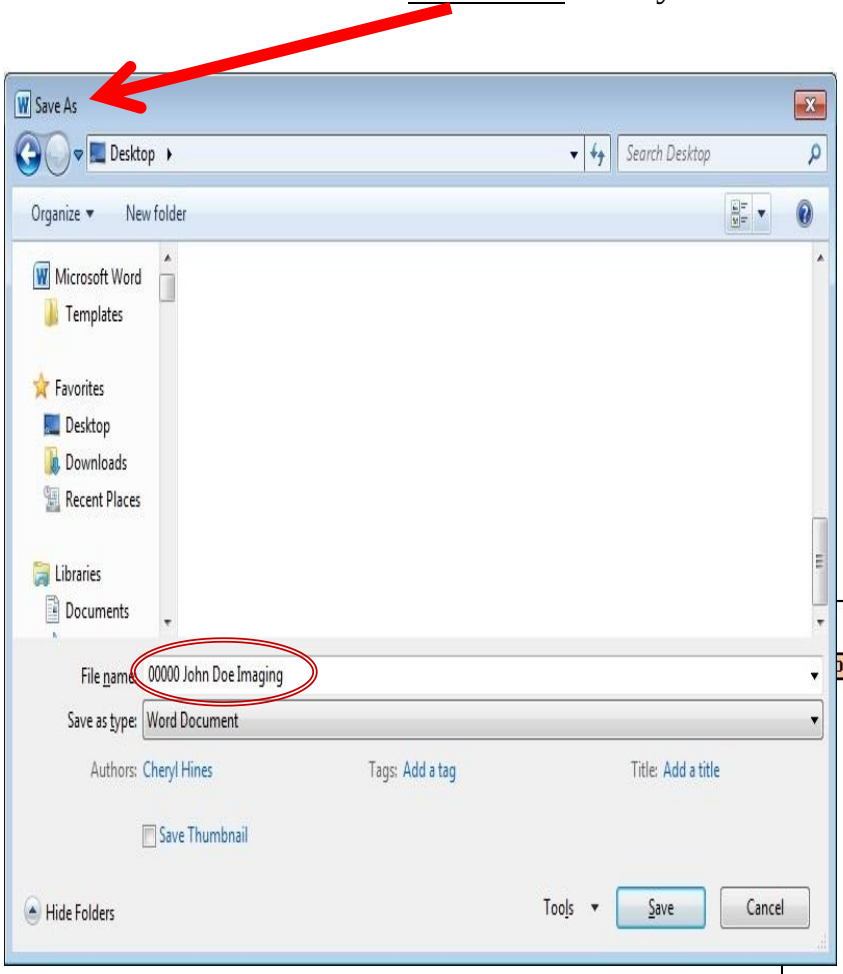
## "Saving your Joint Annual Report Form"

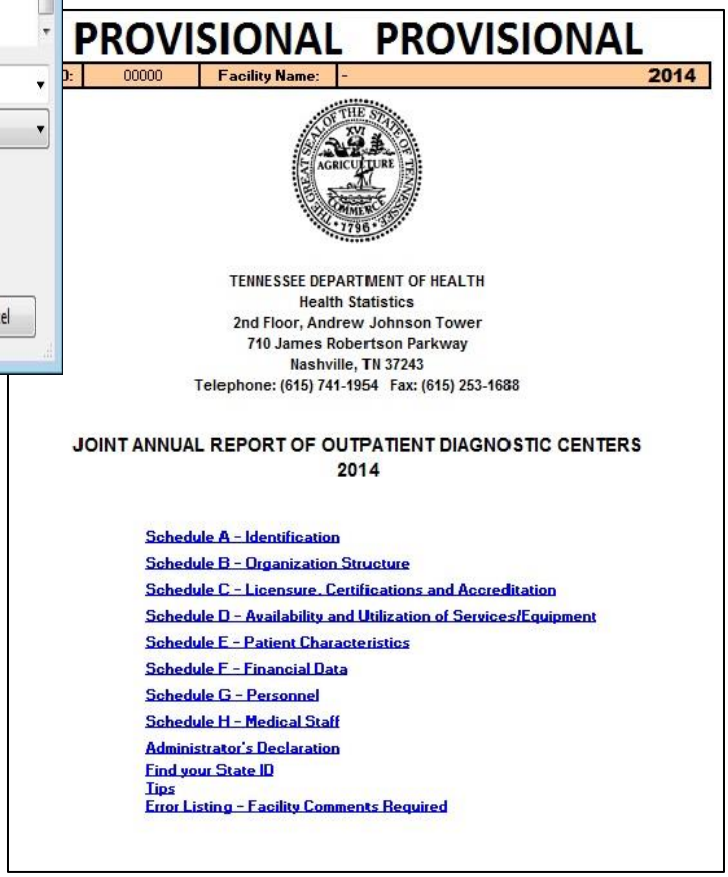
2. Select: **Click here to save the Blank "JAR" data entry form to your computer.**



## "Saving your Joint Annual Report Form"

3. Select File: **SAVE AS** from your menu bar:





PROVISIONAL PROVISIONAL

00000 | Facility Name: - | 2014

TENNESSEE DEPARTMENT OF HEALTH
Health Statistics
2nd Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243
Telephone: (615) 741-1954 Fax: (615) 253-1688

JOINT ANNUAL REPORT OF OUTPATIENT DIAGNOSTIC CENTERS
2014

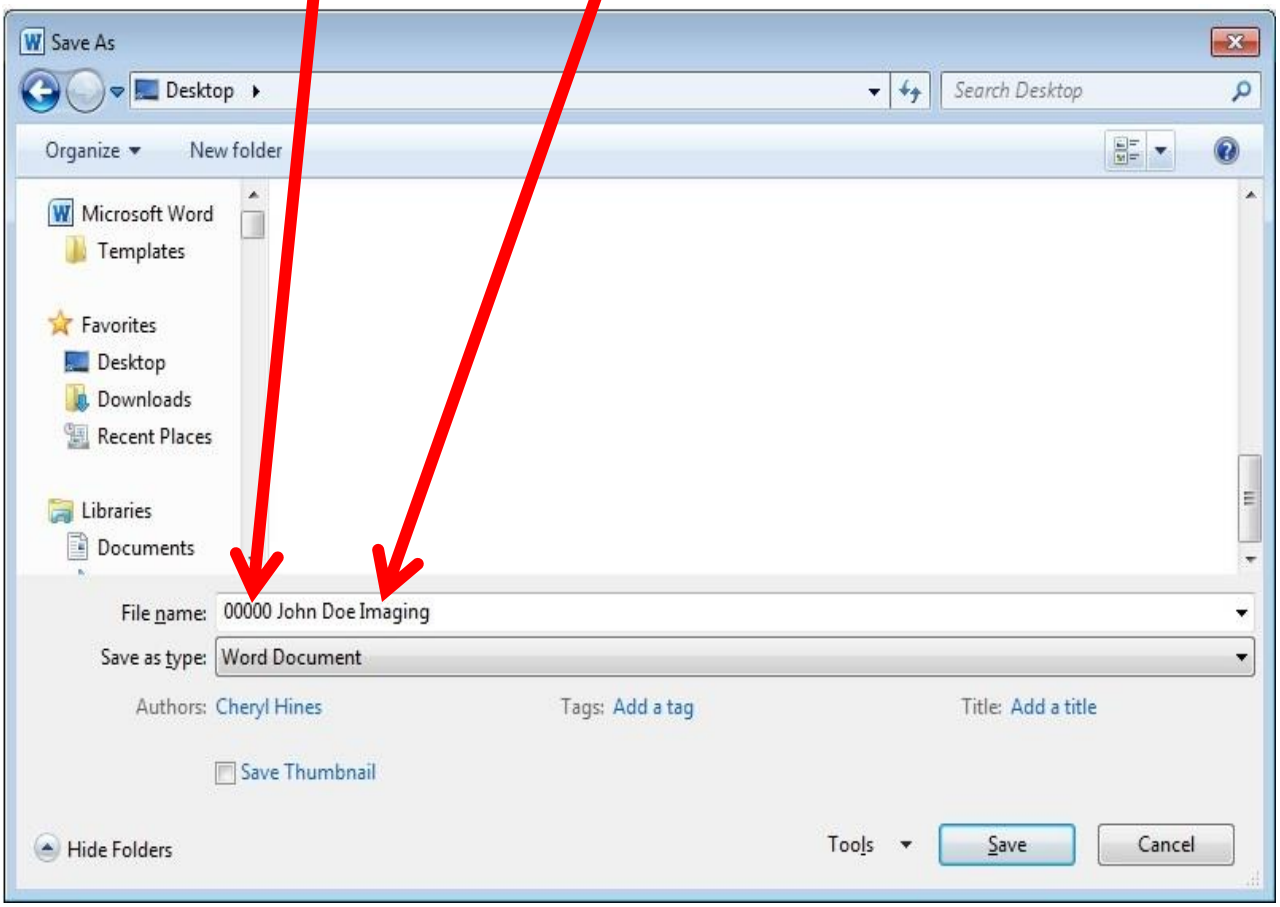
Schedule A – Identification
Schedule B – Organization Structure
Schedule C – Licensure, Certifications and Accreditation
Schedule D – Availability and Utilization of Services/Equipment
Schedule E – Patient Characteristics
Schedule F – Financial Data
Schedule G – Personnel
Schedule H – Medical Staff
Administrator's Declaration
Find your State ID
Tips
Error Listing – Facility Comments Required

## "Saving your Joint Annual Report Form"

4. **NAME** your Joint Annual Report "JAR" Files as:

***Example:*** 00000 John Doe Imaging

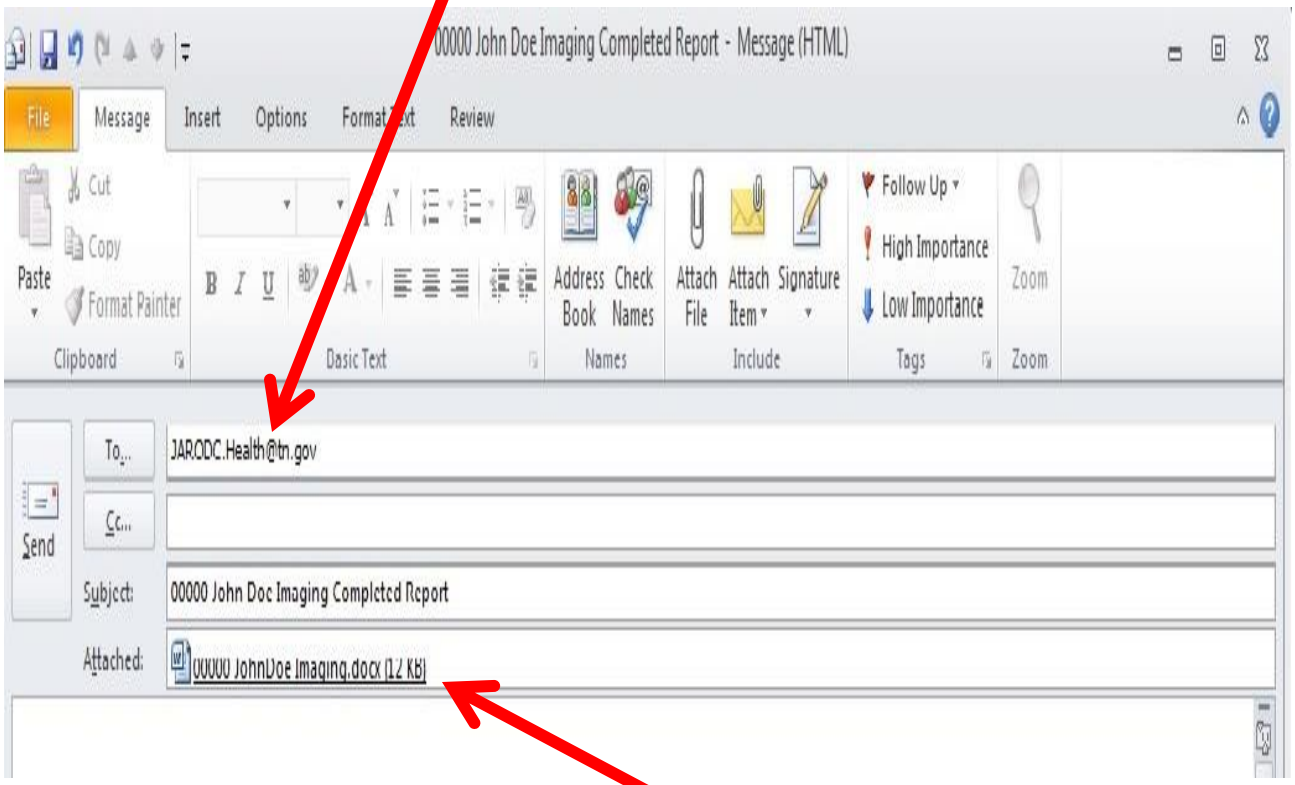
State ID Number  Your Facility Name



## "Saving your Joint Annual Report Form"

5. After having downloaded, saved and completed your facility's ODC Joint Annual Report "JAR" Form. It is time to EMAIL an attached copy of the completed form to the below email address:

EMAIL TO: JARODC.health@tn.gov




**Please include your saved attached file named as:**

***Example:*** 00000 John Doe Imaging

State ID Number  Your Facility Name

*The mission of the Department of Health is to protect, promote and improve the health and prosperity of people in Tennessee.*

# PROVISIONAL PROVISIONAL

| State ID: | 00000 | Facility Name: | - | 2014 |
|---|---|---|---|---|


TENNESSEE DEPARTMENT OF HEALTH
Health Statistics
2nd Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243
Telephone: (615) 741-1954 Fax: (615) 253-1688

## JOINT ANNUAL REPORT OF OUTPATIENT DIAGNOSTIC CENTERS
## 2014



*The mission of the Department of Health is to protect, promote and improve the health and prosperity of people in Tennessee.*

# PROVISIONAL PROVISIONAL

| State ID: | 00000 | Facility Name: | - | 2014 |
|---|---|---|---|---|

**Out Patient Diagnostic Centers - Schedule A - Identification**

According to the Department of Health Rules and Regulations Section 1200-8-35-.11 "the Joint Annual Report of Outpatient Diagnostic Centers shall be filed with the department." Please read all information carefully before completing your Joint Annual Report with data for the calendar year indicated on the first page. Please complete all items on the Joint Annual Report. Use 0 (zero) when appropriate. Check all computations, especially where a total is required. Please check all checkboxes. Any items which appear to be inconsistent will be queried. **Facilities will be reported to the Board for Licensing Health Care Facilities for both failure to file forms and failure to respond to queries.** A section for comments relating to the unique aspect of your agency is available at the end of each schedule.

| | | | | |
|---|---|---|---|---|
| Facility | State ID | 00000 | | |
| | ODC Name | - | | |
| | Did the facility name change during the reporting period? Yes/No | - | | |
| | If Yes, Prior Name | | | |
| | Street Address | - | | |
| | City | - | County | - |
| | State | | Zip Code (5 digit) | - |
| | Phone | | | |
| | Mailing Address same as Street Address? If Yes, proceed to next section. Yes/No | - | | |
| | Mailing Address | | | |
| | City | | | |
| | State | | Zip Code (5 digit) | |
| Preparer | Name | | Phone | |
| | Title | | | |
| | E-Mail | | | |
| Reporting Period | In the event your reporting period differs from that of January 1 through December 31 and/or is less than 365 days, due to new opening or a facility closure, please provide the data along with the beginning and ending dates for the period of time you are reporting. | | | |
| | Is the reporting period January 1 - December 31 of the year specified above? Yes/No | - | | |
| | If unable to report based on above dates, provide beginning and ending dates (used for all utilization and financial data): | | Beginning (mm/dd/yyyy) | |
| | | | Ending (mm/dd/yyyy) | |
| Administration | Administrator's Name | | | |
| | Medical Director's Name | | | |

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Go to Error Listing

# PROVISIONAL PROVISIONAL

| State ID: | 00000 | Facility Name: | - | 2014 |
|---|---|---|---|---|

**Schedule B - Organization Structure**

| | | | | | | |
|---|---|---|---|---|---|---|
| Managed by | Management is provided by: | | If managed by contract or other, provide information below | | | |
| | ^ | Owner | Name | | | |
| | ^ | Contract with Firm | Street | | | |
| | ^ | Other, Specify | City | | Phone | |
| | | | State | | Zip Code | |

| | | |
|---|---|---|
| Building Owner | Name | |
| | Street | |
| | City | Phone |
| | State | Zip Code |

| | | | | | |
|---|---|---|---|---|---|
| Building | Yes/No | - | Do you know the year of the original construction date? If yes: | Year | |
| | Yes/No | - | Has the building had a major renovation? A major renovation is any project that includes the addition of services or medical equipment. If Yes, provide year. | Year | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Type of Facility | Please check Yes or No in each of the four types to describe your facility and include the information requested for that type. | | | | | | |
| | Yes/No | - | Free-Standing | | | | |
| | Yes/No | - | Hospital Based | Name | | | |
| | | | | Street | | | |
| | | | | City | | | |
| | | | | State | | Zip Code | |
| | Yes/No | - | Doctor's Office | Name | | | |
| | | | | Street | | | |
| | | | | City | | | |
| | | | | State | | Zip Code | |
| | Yes/No | - | Other | Specify | | | |
| | | | | Name | | | |
| | | | | Street | | | |
| | | | | City | | | |
| | | | | State | | Zip Code | |

| | | | |
|---|---|---|---|
| Type of Service | Yes/No | - | Multi-Specialty |
| | Yes/No | - | Limited-Purpose |
| | Yes/No | - | Cancer Treatment and Radiation Clinic |
| | Yes/No | - | Other, specify |

| PROVISIONAL PROVISIONAL | | | | | |
|---|---|---|---|---|---|
| State ID: | 00000 | Facility Name: | - | 2014 | |
| Schedule B - Organization Structure | | | | | |
| Owner | Name | | | | |
| | Street | | | | |
| | City | | Telephone | | |
| | State | | Zip Code | | |

The type of legal entity, except proprietorship, general partnerships and government entities, can be confirmed by entering the legal entity's name into a search at the Secretary of State web site: http://www.tennesseeanytime.org/soscorp/.

| | | | | |
|---|---|---|---|---|
| Owner Type | For Profit | ^ | Proprietorship - a business owned by one person. | |
| | | ^ | General Partnership - an association of two or more persons to carry on as co-owners of a business or other undertaking for profit formed under § 61-1-202, predecessor law, or comparable law of another jurisdiction. TCA Title 61 Chapter 1. | |
| | | ^ | Limited Partnership (LP) - a partnership formed by two or more persons under the laws of the state of Tennessee, and having one or more general partners and one or more limited partners. TCA Title 61 Chapter 2. | |
| | | ^ | Limited Liability Partnership (LLP) - governed by TCA § 61-1-106 (c). The law of this state governs relations among the partners and between the partners and the partnership and the liability of partners for an obligation of a limited liability partnership that has filed an application as a limited liability partnership in this state. | |
| | | ^ | Limited Liability Company (LLC) - established by the "The Tennessee Limited Liability Company Act" found in the Tennessee Code Annotated, § 48-201-101 through § 48-248-606. | |
| | | ^ | Corporation - defined by the "Tennessee Business Corporation Act" codified in TCA Title 48 Chapters 11-27. | |
| | Not for Profit | ^ | Non-Religious Corporation or Association - defined by the "Tennessee Nonprofit Corporation Act" codified in TCA Title 48 Chapters 51-68. | |
| | | ^ | Religious Corporation or Association - either a corporation or association that is organized and operated primarily or exclusively for religious purposes. Most of the provisions of the Tennessee Nonprofit Corporation Act apply to a religious corporation. Exceptions are specified in TCA § 48-67-102. | |
| | | ^ | Limited Liability Company (LLC) - a company that is disregarded as an entity for federal income tax purposes, and whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in TCA § 67-4-1004(15). | |
| | Govern-ment | ^ | City | |
| | | ^ | County | |
| | | ^ | State | |
| | | ^ | Federal | |
| | | ^ | Other Government, Specify | |

| PROVISIONAL PROVISIONAL | | | | | | |
|---|---|---|---|---|---|---|
| State ID: | 00000 | Facility Name: | - | | 2014 | |
| Schedule C - Licensure, Certifications and Accreditation | | | | | | |
| Certifications | Yes/No | - | Participation in TennCare | | Provider Number | |
| | Yes/No | - | Participation in Medicare | | Provider Number | |
| Accreditation and Audits | Yes/No | - | Joint Commission on Accreditation of Healthcare Organizations (JCAHO) | | Approval Year | |
| | | | | | Expiration Year | |
| | Yes/No | - | Clinical laboratory Improvement Amendments (CLIA) | | Approval Year | |
| | | | | | Expiration Year | |
| | Yes/No | - | Laboratory Proficiency Testing | | Approval Year | |
| | | | | | Expiration Year | |
| | Yes/No | - | American Association of Blood Banks (AABB) | | Approval Year | |
| | | | | | Expiration Year | |
| | Yes/No | - | American Osteopathic Association (AOA) | | Approval Year | |
| | | | | | Expiration Year | |
| | Yes/No | - | College of American Pathologists (CAP) | | Approval Year | |
| | | | | | Expiration Year | |
| | Yes/No | - | American College of Radiology (ACR) | | Approval Year | |
| | | | | | Expiration Year | |
| | Yes/No | - | Other (1), specify | | Approval Year | |
| | | | | | Expiration Year | |
| | Yes/No | - | Other (2), specify | | Approval Year | |
| | | | | | Expiration Year | |
| | Yes/No | - | Other (3), specify | | Approval Year | |
| | | | | | Expiration Year | |

# PROVISIONAL PROVISIONAL

| State ID: | 00000 | Facility Name: | - | 2014 |
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**Schedule D - Availability and Utilization of Services/Equipment**

If "Yes" provide information requested and indicate the number of patients and diagnostic procedures for those services during the reporting period. Number of patients may include duplicates because the same patient may receive several of the services listed. Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.

**Do not enter zero. Blank fields will represent zero patients and/or procedures.**

| | Type of Service | Yes/No | | | | Patients | Procedures |
|---|---|---|---|---|---|---|---|
| Cardio-pulmonary | Electroencephalogram (EEG) | | | | | | |
| | Electrocardiogram (EKG) | - | | | | | |
| | Holter Monitoring | - | | | | | |
| | Exercise Tolerance Testing | - | | | | | |
| | Cardiac Catheterization | - | | | | | |
| | Percutaneous Transiuminal Coronary Angioplasty | - | | | | | |
| Radiology | Type of Service | Yes/No | | | | Patients | Procedures |
| | Radiography (Diagnostic and Special Procedures- e.g. Angiography) | - | | | | | |
| | Ultrasound (General/Vascular/Cardiac) | - | | | | | |
| | Nuclear Medicine | - | | | | | |
| | Type of Equipment on Site | Yes/No | Number of Units | | If Mobile, number of days per week | Fixed plus Mobile | |
| | | | Fixed | Mobile | | Patients | Procedures |
| | Positron Emission Tomography (PET scan) | - | | | | | |
| | Computed Tomography (CT scan) | - | | | | | |
| | Ultrafast CT | - | | | | | |
| | Magnetic Resonance Imaging (MRI) | - | | | | | |
| | Hi-Field MRI and Open MRI | - | | | | | |
| | Megavoltage Radiation Therapy | - | | | | | |
| | Stereotactic Procedure (including breast Biopsy) | - | | | | | |
| | Mammography | - | | | | | |

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| State ID: | 00000 | Facility Name: | - | 2014 |
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**Schedule D - Availability and Utilization of Services/Equipment**

If "Yes" provide information requested and indicate the number of patients and diagnostic procedures for those services during the reporting period. Number of patients may include duplicates because the same patient may receive several of the services listed. Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.

**Do not enter zero. Blank fields will represent zero patients and/or procedures.**

| | Type of Service | Yes/No | | | | Patients | Procedures |
|---|---|---|---|---|---|---|---|
| Other | Vascular Embolization | - | | | | | |
| | Anesthesia | - | | | | | |
| | Ultrasound (ACR Accredited Breast/ Pelvic/OB) | - | | | | | |
| | Chemotherapy | - | | | | | |
| | Type of Equipment on Site | Yes/No | Number of Units | | If Mobile, number of days per week | Fixed plus Mobile | |
| | | | Fixed | Mobile | | Patients | Procedures |
| | Lithotripsy | - | | | | | |
| | Bone Densitometry | - | | | | | |
| | Other, Specify | - | | | | | |
| | | | | | | | |
| Total | Total number of patients and diagnostic procedures during this reporting period. | | | | | 0 | 0 |
| | Total Unduplicated Patients: The number of actual individuals served during the reporting period. This may be less than the number of patients and diagnostic procedures reported. | | | | | | |
| Rooms | Number of Diagnostic Procedure rooms. | | | | | | |

# PROVISIONAL PROVISIONAL

| State ID: | 00000 | Facility Name: | - | 2014 |
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**Schedule E - Patient Characteristics**

**Do not enter zero. Blank fields will represent zero patients.**

| | Age | Gender | | Total Patients Served | Race | | |
|---|---|---|---|---|---|---|---|
| | | Male | Female | | White | Black | Other |
| Number of Patients Served By Age, Gender, and Race | 17 and Under | | | 0 | | | |
| | 18-64 | | | 0 | | | |
| | 65-84 | | | 0 | | | |
| | 85 and Older | | | 0 | | | |
| | Total Patients | 0 | 0 | 0 | 0 | 0 | 0 |
| | Total Patients Served should match Total Unduplicated Patients in Schedule D. | | | | | | |

Please record the number of Tennessee and Non-Tennessee patients who received services during the reporting period.

Number of Patients Served by Patient Origin

Tennessee Patients

| County | Number of Patients | County | Number of Patients | County | Number of Patients |
|---|---|---|---|---|---|
| 1 Anderson | | 33 Hamilton | | 65 Morgan | |
| 2 Bedford | | 34 Hancock | | 66 Obion | |
| 3 Benton | | 35 Hardeman | | 67 Overton | |
| 4 Bledsoe | | 36 Hardin | | 68 Perry | |
| 5 Blount | | 37 Hawkins | | 69 Pickett | |
| 6 Bradley | | 38 Haywood | | 70 Polk | |
| 7 Campbell | | 39 Henderson | | 71 Putnam | |
| 8 Cannon | | 40 Henry | | 72 Rhea | |
| 9 Carroll | | 41 Hickman | | 73 Roane | |
| 10 Carter | | 42 Houston | | 74 Robertson | |
| 11 Cheatham | | 43 Humphreys | | 75 Rutherford | |
| 12 Chester | | 44 Jackson | | 76 Scott | |
| 13 Claiborne | | 45 Jefferson | | 77 Sequatchie | |
| 14 Clay | | 46 Johnson | | 78 Sevier | |
| 15 Cocke | | 47 Knox | | 79 Shelby | |
| 16 Coffee | | 48 Lake | | 80 Smith | |
| 17 Crockett | | 49 Lauderdale | | 81 Stewart | |
| 18 Cumberland | | 50 Lawrence | | 82 Sullivan | |
| 19 Davidson | | 51 Lewis | | 83 Sumner | |
| 20 Decatur | | 52 Lincoln | | 84 Tipton | |
| 21 DeKalb | | 53 Loudon | | 85 Trousdale | |
| 22 Dickson | | 54 McMinn | | 86 Unicoi | |
| 23 Dyer | | 55 McNairy | | 87 Union | |
| 24 Fayette | | 56 Macon | | 88 Van Buren | |
| 25 Fentress | | 57 Madison | | 89 Warren | |
| 26 Franklin | | 58 Marion | | 90 Washington | |
| 27 Gibson | | 59 Marshall | | 91 Wayne | |
| 28 Giles | | 60 Maury | | 92 Weakley | |
| 29 Grainger | | 61 Meigs | | 93 White | |
| 30 Greene | | 62 Monroe | | 94 Williamson | |
| 31 Grundy | | 63 Montgomery | | 95 Wilson | |
| 32 Hamblen | | 64 Moore | | 96 Unknown | |
| | | | | Total Tennessee Patients | 0 |

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| State ID: | 00000 | Facility Name: | - | 2014 |
|---|---|---|---|---|

**Schedule E - Patient Characteristics**

**Do not enter zero. Blank fields will represent zero patients.**

| Number of Patients Served by Patient Origin | State | Number of Patients | State | Number of Patients | State | Number of Patients |
|---|---|---|---|---|---|---|
| | 01 Alabama | | 18 Kentucky | | 34 North Carolina | |
| | 04 Arkansas | | 25 Mississippi | | 47 Virginia | |
| | 11 Georgia | | 26 Missouri | | 55 Other State or Country | |
| Out-of-state Patients | Total Non-Tennessee Patients | | | | | 0 |
| | Total of Tennessee and Non-Tennessee Patients | | | | | 0 |

# PROVISIONAL PROVISIONAL

| State ID: | 00000 | Facility Name: | - | 2014 |
|---|---|---|---|---|

**Schedule F - Financial Data**

| Round all figures to the nearest dollar. | | Amount |
|---|---|---|
| Expenses | Payroll - Include salaries for all full-time and part-time personnel who are included in Schedule G. | - |
| | Fringe Benefits - Social security, group insurance, retirement benefit, etc. | - |
| | Other Operating Expenses - Expenses for all contract staff, professional fees, energy expense (oil, natural gas, electricity, etx.), and all other operating expenses. | - |
| | Depreciation Expense. | - |
| | Non-Operating Expense - Include all other expenses for interest, taxes, real estate ease expenses, and other non-operating expenses. | - |
| | Total | $0 |

Gross Patient Charges - The sum of the facility's established rate for all services rendered to patients during the reporting year.
Adjustments to Charges - The difference between the gross patient charges and the actual amount of payment received by the facility during the reporting period. Adjustments to previous years revenue, such as Medicare or TennCare prior adjustments, should be reported as non-operating revenue, not as current year adjustments.
Net Patient Revenue - The difference obtained by subtracting adjustments to charges from gross patient charges. This difference represents the actual amount of revenue that the facility received.

| Patient Revenue | | Revenue Source | Gross Patient Charges | - | Adjustment to Charges | = | Net Patient Revenue |
|---|---|---|---|---|---|---|---|
| | Government | Medicare | - | - | - | = | #VALUE! |
| | | TennCare | - | - | - | = | #VALUE! |
| | | Other Government | - | - | - | = | #VALUE! |
| | | Total Government | $0 | - | $0 | = | $0 |
| | Non-Government | Self-Pay | - | - | - | = | #VALUE! |
| | | Insurance | - | - | - | = | #VALUE! |
| | | Other Non-Government | - | - | - | = | #VALUE! |
| | | Total Non-Government | $0 | - | $0 | = | $0 |
| | Total Patient Revenue: (Total Government plus Total Non-Government) | | $0 | - | $0 | = | $0 |
| | All Non-Patient Revenue | | | | | | - |
| | Total Net Revenue: Net Total Patient Revenue plus All Non-Patient Revenue | | | | | | #VALUE! |

| Non-Government Adjustment to Charges Subcategories | | |
|---|---|---|
| | Bad Debt - Uncompensated care for which the facility directly billed the patient and for which the patient should reasonably be expected to pay. | - |
| | Charity Care - Services provided to medically needy persons for which the facility does not expect payment. | - |
| | Other - Any other adjustments that are not appropriately reported in either Bad Debt or Charity. | - |
| | Total Non-Government Adjustment to Charges Subcategories | $0 |

# PROVISIONAL PROVISIONAL

| State ID: | 00000 | Facility Name: | - | 2014 |
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**Schedule G - Personnel**

**Do not enter zero. Blank fields will represent zero personnel.**

Type of Personnel by Service

Please indicate the number of paid personnel as of the last day of the reporting period. Do not include a type of personnel for which you do not provide that type of service. For example, do not include Physical Therapists unless you provide Physical Therapy services.
Leave the item blank if the value is unknown. Full Time Equivalent (FTE) = Number of hours worked by part-time employees per week/40 hours per week. For example, three Registered Nurses, each working 20 hours a week, the FTE would be (3x20)/40=1.5. Additional examples of FTEs:
40 hours = 1 FTE; 30 hours = .75 FTE; 20 hours = .5 FTE; 10 hours = .25 FTE. For the purposes of this calculation, if your agency reimburses employees per visit rather than per hour worked, one visit equals one hour in FTE. The sum of full-time personnel plus part-time personnel (in full-time equivalents) added together equal the total number of full-time equivalents.

| Type | Number of Personnel by type | | | |
|---|---|---|---|---|
| | Employee | | Contract | |
| | Full-Time | Part-Time In FTE | Full-Time | Part-Time In FTE |
| Administrators | | | | |
| Medical Director | | | | |
| Physicians (M.D. And D.O.) | | | | |
| Dentists | | | | |
| Financial/Billing Personnel | | | | |
| Nursing (R.N., L.P.N., and Ancillary) | | | | |
| Medical Records | | | | |
| Registered Technologist | | | | |
| Technical | | | | |
| Maintenance/Services | | | | |
| Other 1, Specify | | | | |
| Other 2, Specify | | | | |
| Other 3, Specify | | | | |
| Total | 0 | 0.00 | 0 | 0.00 |

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| State ID: | 00000 | Facility Name: | - | 2014 |
|---|---|---|---|---|

**Schedule G - Personnel**

**Do not enter zero. Blank fields will represent zero personnel.**

Please indicate the number of personnel as of the last day of the reporting period.

**Nursing Personnel**

| | Highest Education Level | Number Currently Employed | Number of Budgeted Vacancies | Average # Weeks Required to Recruit Staff | Number Added in the Past 12 Months | Number Eliminated in the Past 12 Months | |
|---|---|---|---|---|---|---|---|
| | | | | | | Clinical | Admin |
| Registered Nurses | Associate | | | | | | |
| | Diploma | | | | | | |
| | Bachelors | | | | | | |
| | Masters | | | | | | |
| | Doctorate | | | | | | |
| | Total | 0 | 0 | | 0 | 0 | 0 |

| | Category | Number Currently Employed | Number of Budgeted Vacancies | Average # Weeks Required to Recruit Staff | Number Added in the Past 12 Months | Number Eliminated in the Past 12 Months | |
|---|---|---|---|---|---|---|---|
| | | | | | | Clinical | Admin |
| Advanced Practice Nurses | Nurse Practitioner | | | | | | |
| | Clinical Nurse Specialist | | | | | | |
| | Certified Registered Nurse Anesthetist | | | | | | |
| | Total | 0 | 0 | | 0 | 0 | 0 |

| | Other Nursing Staff | Number Currently Employed | Number of Budgeted Vacancies | Average #Weeks Required to Recruit Staff | Number added in the Past 12 Months | Number Eliminated in the Past 12 Months |
|---|---|---|---|---|---|---|
| Other Nurses | Licensed Practical Nurses | | | | | |
| | Certified Nurses Aides | | | | | |
| | Other 1, Specify | | | | | |
| | | | | | | |
| | Other 2, Specify | | | | | |
| | | | | | | |

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|---|---|---|---|---|---|---|---|
| State ID: | 00000 | Facility Name: | - | | | | 2014 |
| Schedule G - Personnel | | | | | | | |
| Do not enter zero. Blank fields will represent zero personnel. | | | | | | | |
| | | Yes/No | - | Does your organization use contract nursing personnel? | | | |
| | | If yes, indicate the number of contract personnel in the following categories: | | | | | |
| | Contract Nursing | | Number Currently Employed | Number of Budgeted Vacancies | Average #Weeks Required to Recruit Staff | Number added in the Past 12 Months | Number Eliminated in the Past 12 Months |
| | | Registered Nurses | | | | | |
| | | Licensed Practical Nurses | | | | | |
| | | Certified Nurse Aids | | | | | |

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| State ID: | 00000 | Facility Name: | - | 2014 |
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**Out Patient Diagnostic Centers - Schedule H - Medical Staff**

**Do not enter zero. Blank fields will represent zero medical staff.**

Include all physicians, whether considered active or associate.
Active: Employed and practicing at the facility
Associate: Has privileges to practice at the facility but is not employed at the facility

| | Specialty | | Total Number of Medical Staff | Number of Medical Staff who are Board Certified |
|---|---|---|---|---|
| Medical Staff | Cardiologist | | | |
| | Neurologists | | | |
| | Pathologist | | | |
| | Radiologist | | | |
| | Technician | | | |
| | Other 1, specify | | | |
| | Other 2, specify | | | |

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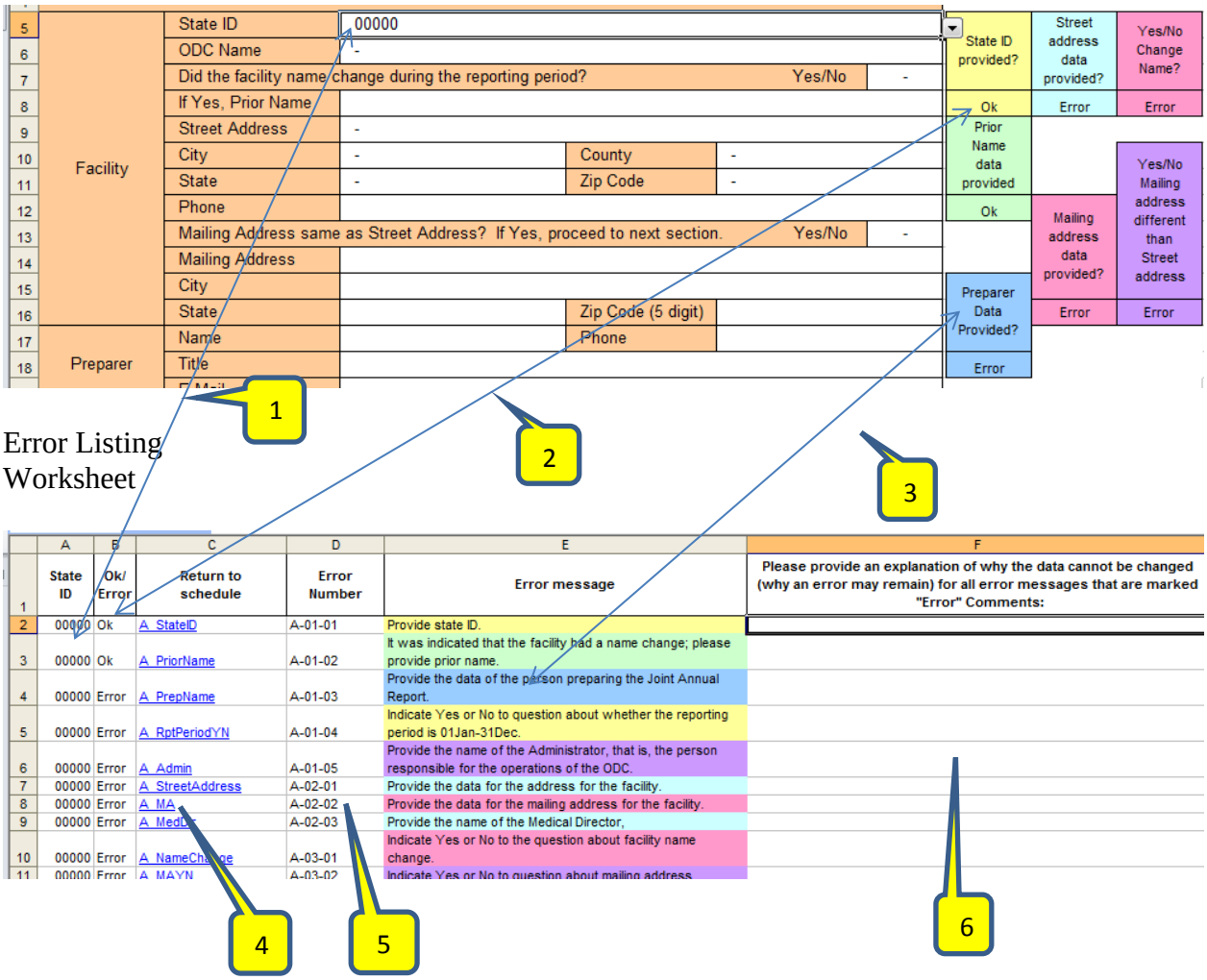
|---|---|---|---|---|
| State ID: | 00000 | Facility Name: | - | 2014 |
| Out Patient Diagnostic Centers - Schedule Adm Dec - Administrator's Declaration | | | | |
| Administrator's Declaration | - | I, the administrator, declare that I have examined this report and to the best of my knowledge and belief, it is true, correct, and complete. | | |
| Date (mm/dd/yyyy) (use slashes) | | | | |

**Printing** – Each schedule can be printed individually. Please note if you print the entire file, you will print over 20 pages including the State ID's and Error listing worksheets.

Schedule A




Error Listing Worksheet




1. State ID from Schedule A will be populated by the system in column A of the Error Listing worksheet for each error question in the JAR.
2. Error message (Ok or Error) will be populated by the system from each error in all schedules.
3. Error message color will match on the schedule and in the Error Listing worksheet. A more detailed explanation of the error is in the Error Listing worksheet.
4. This is a hyperlink which will return you to the schedule with the error. The cell you are returned to will be the first possible cell where the error may reside; however, this cell may not contain the error in question.

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**Printing** continued

5. Error Number is a listing of the errors. The format for the error number A-01-02, A represents the schedule in this example A. 01 represents the first column of errors starting in column "AL". 02 represent the error number for the column in order from top to bottom.
6. Used to provide an explanation of why the data is not a true error.

# Joint Annual Report of Outpatient Diagnostic Centers
# 2014 Tips to Avoid Common Errors

The following guidelines are written to assist you to complete the Joint Annual Report for the Outpatient Diagnostic Center 2013 reporting year.

A. A User Manual can be found on the website http://health.state.tn.us/statistics/jarodc.htm. Please read all information carefully before completing your Joint Annual Report. Keep the manual and these tips handy as you will need them to fill out the form and export the data. For your reference, this Tips document is also included as a Tab on the Excel data entry form.

B. Please complete all items on the report form.
   (1) Use 0 (zero) when appropriate rather than leaving the item blank.
   (2) Please select the appropriate answer to all (Yes / No) questions.
   (3) Check all computations, especially where a total is required.
   (4) Corporate offices that do data entry for several facilities must close out between each facility to avoid system generated errors. It is requested that you work on one (1) facility at a time.

   (5) In the event that a reporting period other than January1 through December 31 is used by your facility for statistical information, please report that data including the actual beginning and ending dates of your facilities' reporting period.

C. Any item which appears to be inconsistent will be queried. Report forms with items left blank will not be acceptable. ***The Tennessee Department of Health's Bureau of Health Licensure and Regulation may issue deficiencies for either failing to file forms or submission of incomplete forms.***

## SCHEDULE A – IDENTIFICATION

**Facility**

State ID: Select your State ID from the drop down list first. Facility name and address are filled in automatically, unless there is a name change in which case your facility's new name and your facility's new address has to be typed in manually.

Reporting Period: All facilities are requested to report data based on the twelve month period for the calendar year. If reporting period is January 1 through December 31, leave date lines blank.

Use Proper Case and not ALL CAPS in Schedule A; such as facility name, address, and city.

Please fill in the e-mail address of the preparer of your facility's report, so that we may use this address as a means of initial contact.

## SCHEDULE B – ORGANIZATION STRUCTURE

**Owner Type**

Please place an "X" in only **one** block of the For Profit, Not for Profit or Government Section.

## SCHEDULE C – LICENSURE, CERTIFICATIONS AND ACCREDITATION

Please fill in provider numbers. The data field for year of accreditation/audit takes only the four digit year. Do not put in a complete date. Answer all Yes/No questions.

## SCHEDULE D – AVAILABILITY AND UTILIZATION OF SERVICES/EQUIPMENT

Fill in the number of patients and diagnostic procedures and number of fixed and mobile units as well as number of days per week for mobile. The total unduplicated patients on this schedule should match the total patients by age, gender, and race in Schedule E.